FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029975

Facility Name: WILSON CARE INC.

Address: 4544 N. HAZEL STREET (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 561-7241 **Fax #** (773) 728-2606

IDPA ID Number: 363379568001

Date of Initial License for Current Owners: 09/01/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) CARY C. BUXBAUM, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	198	Intermediate (ICF)	198	72,270	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	198	TOTALS	198	72,270	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	64,808	1,039		65,847	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,808	1,039		65,847	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.11%

D. How many bed-hold days during this year were paid by Public Aid?
1,861 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/31/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	165,937	26,547	32,196	224,680		224,680	(18,850)	205,830			1
2	Food Purchase		232,823		232,823	(17,739)	215,084	(37)	215,047			2
3	Housekeeping	116,146	28,158		144,304		144,304	718	145,022			3
4	Laundry		14,850	6,972	21,822		21,822		21,822			4
5	Heat and Other Utilities			107,711	107,711		107,711	2,209	109,920			5
6	Maintenance	37,174	26,238	173,485	236,897		236,897	(62,101)	174,796			6
7	Other (specify):*							9,454	9,454			7
8	**TOTAL General Services**	319,257	328,616	320,364	968,237	(17,739)	950,498	(68,607)	881,891			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	980,406	11,153	85,789	1,077,348		1,077,348	(19,704)	1,057,644			10
10a	Therapy			17,580	17,580		17,580	(4,709)	12,871			10a
11	Activities	96,439	6,684		103,123		103,123		103,123			11
12	Social Services	277,980		9,193	287,173		287,173		287,173			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							6,932	6,932			15
16	**TOTAL Health Care and Programs**	1,354,825	17,837	114,962	1,487,624		1,487,624	(17,481)	1,470,143			16
	C. General Administration											
17	Administrative	100,076		307,342	407,418		407,418	(92,467)	314,951			17
18	Directors Fees											18
19	Professional Services			172,774	172,774	(382)	172,392	(104,905)	67,487			19
20	Dues, Fees, Subscriptions & Promotions			28,097	28,097		28,097	(9,534)	18,563			20
21	Clerical & General Office Expenses	81,697	21,753	60,203	163,653		163,653	35,398	199,051			21
22	Employee Benefits & Payroll Taxes			287,475	287,475	17,739	305,214		305,214			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,138	2,138		2,138	263	2,401			24
25	Other Admin. Staff Transportation			3,525	3,525		3,525	1,150	4,675			25
26	Insurance-Prop.Liab.Malpractice			104,007	104,007		104,007	1,155	105,162			26
27	Other (specify):*							31,294	31,294			27
28	**TOTAL General Administration**	181,773	21,753	965,561	1,169,087	17,357	1,186,444	(137,646)	1,048,798			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,855,855	368,206	1,400,887	3,624,948	(382)	3,624,566	(223,734)	3,400,832			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WILSON CARE INC. #0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			94,397	94,397		94,397	81,699	176,096			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,910	3,910		3,910	464,506	468,416			32
33	Real Estate Taxes			73,635	73,635	382	74,017	5,986	80,003			33
34	Rent-Facility & Grounds			614,280	614,280		614,280	(614,280)				34
35	Rent-Equipment & Vehicles			13,450	13,450		13,450	7,555	21,005			35
36	Other (specify):*							10,991	10,991			36
37	**TOTAL Ownership**			799,672	799,672	382	800,054	(43,543)	756,511			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,405	108,405		108,405		108,405			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			108,405	108,405		108,405		108,405			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,855,855	368,206	2,308,964	4,533,025		4,533,025	(267,276)	4,265,749			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,525)	30		9
10	Interest and Other Investment Income	(18,816)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(37)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,944)	21		24
25	Fund Raising, Advertising and Promotional	(3,443)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(63,460)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (101,474)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(165,803)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (165,803)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (267,276)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

WILSON CARE INC.

ID# 0029975

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty	$ (241)	10	1
2	IL. Council Cope	(3,101)	20	2
3	Theft	(100)	21	3
4	State Replacement Tax	(19,088)	21	4
5	Contribution-Building	(500)	20	5
6	Non-allowable travel expense	(1,526)	25	6
7	Capitalize R & M	(38,600)	06	7
8	Misc Income	(304)	35	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(63,460)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(18,850)							(18,850)	1
2	Food Purchase	(37)											(37)	2
3	Housekeeping			718									718	3
4	Laundry													4
5	Heat and Other Utilities			903	1,306								2,209	5
6	Maintenance	(38,600)		637	(11,319)	(12,819)							(62,101)	6
7	Other (specify):*				991	8,463							9,454	7
8	**TOTAL General Services**	(38,637)		2,258	(9,022)	(23,206)							(68,607)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(241)			(18,633)			(831)					(19,704)	10
10a	Therapy					(4,709)							(4,709)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				4,264	2,668							6,932	15
16	**TOTAL Health Care and Programs**	(241)			(14,369)	(2,041)		(831)					(17,481)	16
	C. General Administration													
17	Administrative			16,617	(60,564)	(44,411)			(4,109)				(92,467)	17
18	Directors Fees													18
19	Professional Services			(100,451)	(11,089)	6,601			34				(104,905)	19
20	Fees, Subscriptions & Promotions	(10,294)	500	222	18				20				(9,534)	20
21	Clerical & General Office Expenses	(26,132)		55,591	5,773				166				35,398	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			44	219								263	24
25	Other Admin. Staff Transportation	(1,526)		652	2,024								1,150	25
26	Insurance-Prop.Liab.Malpractice			487	668								1,155	26
27	Other (specify):*			10,778	5,868	14,359			289				31,294	27
28	**TOTAL General Administration**	(37,951)	500	(16,060)	(57,083)	(23,451)			(3,600)				(137,646)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(76,829)	500	(13,802)	(80,474)	(48,698)		(831)	(3,600)				(223,734)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILSON CARE INC. # 0029975 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(5,525)	81,609	2,369	3,246								81,699	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(18,816)	478,397	1,204	3,721								464,506	32
33	Real Estate Taxes			2,133	3,853								5,986	33
34	Rent-Facility & Grounds		(614,280)										(614,280)	34
35	Rent-Equipment & Vehicles	(304)		3,227	4,632								7,555	35
36	Other (specify):*		10,991										10,991	36
37	**TOTAL Ownership**	(24,645)	(43,283)	8,933	15,452								(43,543)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(101,474)	(42,783)	(4,869)	(65,022)	(48,698)		(831)	(3,600)				(267,276)	45

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached				
				See Shedule Attached		
				Wilson Care LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 614,280	Wilson Care LLC		$	$ (614,280)	1
2	V								2
3	V	32	Interest Income	65	Wilson Care LLC			(65)	3
4	V								4
5	V	36	Amortization		Wilson Care LLC		10,991	10,991	5
6	V	30	Depreciation		Wilson Care LLC		81,609	81,609	6
7	V	32	Interest Expense		Wilson Care LLC		478,462	478,462	7
8	V								8
9	V	20	Political Contribution		Wilson Care LLC		500	500	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 614,345			$ 571,562	$ * (42,783)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 718	$ 718	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	903	903	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	637	637	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,617	16,617	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,575	2,575	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	222	222	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	55,591	55,591	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	44	44	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	652	652	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	487	487	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	10,778	10,778	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,369	2,369	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,204	1,204	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,133	2,133	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	3,227	3,227	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	103,026	PREFERRED BOOKKEEPING	100.00%		(103,026)	32
33	V	19	COMPUTER	4,752	PREFERRED BOOKKEEPING	100.00%	4,752		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 107,778			$ 102,909	$ * (4,869)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,306	$ 1,306	15
16	V	6	REPAIRS AND MAINT.	17,820	S.I.R. MANAGEMENT, INC.	100.00%	6,501	(11,319)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	991	991	17
18	V	10	NURSING	39,204	S.I.R. MANAGEMENT, INC.	100.00%	20,571	(18,633)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,264	4,264	19
20	V	17	ADMINISTRATIVE	69,492	S.I.R. MANAGEMENT, INC.	100.00%	8,928	(60,564)	20
21	V	19	PROFESSIONAL FEES	16,044	S.I.R. MANAGEMENT, INC.	100.00%	4,955	(11,089)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	18	18	22
23	V	21	CLERICAL & GENERAL	20,196	S.I.R. MANAGEMENT, INC.	100.00%	25,969	5,773	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	219	219	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,024	2,024	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	668	668	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,868	5,868	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,246	3,246	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,721	3,721	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,853	3,853	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,632	4,632	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 162,756			$ 97,734	$ * (65,022)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 20,196	S.I.R. MANAGEMENT, INC.	100.00%	$ 6,499	$ (13,697)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,347	1,347	16
17	V	17	ADMIN./LEGAL SALARIES	120,000	S.I.R. MANAGEMENT, INC.	100.00%	40,733	(79,267)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	13,729	13,729	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	6,952	6,952	19
20	V								20
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%	26,746	26,746	21
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,293	4,293	22
23	V								23
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%	20,709	20,709	24
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,114	3,114	25
26	V								26
27	V	10A	SPECIAL REHAB	17,580	S.I.R. MANAGEMENT, INC.	100.00%	12,871	(4,709)	27
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	2,668	2,668	28
29	V								29
30	V	6	REPAIRS AND MAINT.	40,302	S.I.R. MANAGEMENT, INC.	100.00%	27,483	(12,819)	30
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	5,697	5,697	31
32	V								32
33	V	1	DIETICIAN SALARIES	12,000	S.I.R. MANAGEMENT, INC.	100.00%	6,847	(5,153)	33
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,419	1,419	34
35	V								35
36	V	19	LEGAL FEES	7,128	S.I.R. MANAGEMENT, INC.	100.00%		(7,128)	36
37	V								37
38	V	17	COUNCIL DUES	12,600	S.I.R. MANAGEMENT, INC.	100.00%		(12,600)	38
39	Total			$ 229,806			$ 181,108	$ * (48,698)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 57,285	$ 57,285	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	57,285	CCS EMPLOYEE BENEFIT GROUP	100.00%		(57,285)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 57,285			$ 57,285	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	XCEL Medical Supply, LLC	100.00%	$	$	15
16	V	03	Housekeeping		XCEL Medical Supply, LLC	100.00%			16
17	V	10	Nursing	6,133	XCEL Medical Supply, LLC	100.00%	5,302	(831)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,133			$ 5,302	$ * (831)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 34	$ 34	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	20	20	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	166	166	17
18	V	17	MANAGEMENT FEES	9,000	ECM OWNERS COUNCIL	100.00%		(9,000)	18
19	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	4,891	4,891	19
20	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	289	289	20
21	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%			21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,000			$ 5,400	$ * (3,600)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	HOWARD GELLER	SHAREHOLDER	Administrative	4.44%	See Attached	2	3.34%	Mgmt Fees	$ 48,000	17-3	1
2	NOAH WOLFF	SHAREHOLDER	Administrative	5.56%	See Attached	3	7.15%	Mgmt Fees	48,000	17-3	2
3	NENITA GUZMAN	RELATIVE	Dietary	0	See Attached	5.24	10.48%	All. Salary	6,499	01-7	3
4	ARTURO ROMINIQUIT	RELATIVE	Clerical	0	See Attached	4.03	10.99%	All. Salary	2,597	21-7	4
5	BRYAN BARRISH	SHAREHOLDER	Administrative	4.86%	See Attached	5.64	16.12%	All. Salary	26,746	17-7	5
6	ERIC ROTHNER	SHAREHOLDER	Administrative	20.00%	See Attached	0.66	0.92%	All. Salary	1,847	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 133,689		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	938,058	11	$ 6,541	$	103,026	$ 718	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	938,058	11	8,219		103,026	903	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	938,058	11	5,799		103,026	637	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	938,058	11	151,295	151,295	103,026	16,617	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	938,058	11	23,448		103,026	2,575	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	938,058	11	2,020		103,026	222	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	938,058	11	506,159	442,988	103,026	55,591	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	938,058	11	400		103,026	44	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	938,058	11	5,937		103,026	652	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	938,058	11	4,435		103,026	487	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	938,058	11	98,137		103,026	10,778	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	938,058	11	21,566		103,026	2,369	12
13	32	INTEREST	BOOK./ACCNT.INCOME	938,058	11	10,965		103,026	1,204	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	938,058	11	19,425		103,026	2,133	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	938,058	11	29,379		103,026	3,227	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						4,752	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 893,725	$ 594,283		$ 102,909	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	628,177	10	$ 12,461	$	65,847	$ 1,306	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	628,177	10	62,016	45,622	65,847	6,501	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	628,177	10	9,458		65,847	991	3
4	10	NURSING	PATIENT DAYS	628,177	10	196,243	196,243	65,847	20,571	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	628,177	10	40,682		65,847	4,264	5
6	17	ADMINISTRATIVE	PATIENT DAYS	628,177	10	85,174	85,174	65,847	8,928	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	628,177	10	47,273		65,847	4,955	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	628,177	10	176		65,847	18	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	628,177	10	247,745	202,804	65,847	25,969	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	628,177	10	2,093		65,847	219	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	628,177	10	19,306		65,847	2,024	11
12	26	INSURANCE	PATIENT DAYS	628,177	10	6,377		65,847	668	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	628,177	10	55,976		65,847	5,868	13
14	30	DEPRECIATION	PATIENT DAYS	628,177	10	30,963		65,847	3,246	14
15	32	INTEREST	PATIENT DAYS	628,177	10	35,501		65,847	3,721	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	628,177	10	36,759		65,847	3,853	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	628,177	10	44,185		65,847	4,632	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 932,388	$ 529,843		$ 97,734	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	628,177	10	$ 62,004	$ 62,004	65,847	$ 6,499	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	628,177	10	12,854		65,847	1,347	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	628,177	10	388,593	388,593	65,847	40,733	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	628,177	10	130,972		65,847	13,729	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	628,177	10	$ 66,321	$	65,847	$ 6,952	5
6										6
7	17	ADMIN. SALARY	AVG HRS WKD	35	10	165,979	165,979	6	26,746	7
8	27	EMP. BEN.-ADMIN.	AVG HRS WKD	35	10	26,644		6	4,293	8
9						$	$		$	9
10	17	ADMIN SALARY	AVG HRS WKD	40	10	128,429	128,429	6	20,709	10
11	27	EMP. BEN.-ADMIN.	AVG HRS WKD	40	10	19,310		6	3,114	11
12										12
13	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	$ 60,726	$ 60,726	17,580	$ 12,871	13
14	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	12,589		17,580	2,668	14
15										15
16	6	REPAIRS AND MAINT.	MAINTENANCE INC.	177,156	10	120,809	120,809	40,302	27,483	16
17	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	177,156	10	25,044		40,302	5,697	17
18										18
19	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	71,551	71,551	12,000	6,847	19
20	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	14,833		12,000	1,419	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,306,658	$ 998,091		$ 181,108	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 57,285	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 57,285	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)3287615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$	1
2	03	Housekeeping	Direct Allocation							2
3	10	Nursing	Direct Allocation						5,302	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 5,302	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	40,000	9	$ 150	$	9,000	$ 34	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	40,000	9	89		9,000	20	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	40,000	9	739		9,000	166	3
4	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	40,000	9			9,000		4
5	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	38	9	29,045	29,045	6	4,891	5
6	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	38	9	1,713		6	289	6
7	17	ADMIN. SALARY	DIRECT ALLOCATION		7	(2,635)				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 29,101	$ 29,045		$ 5,400	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Nomura		X	Mortgage	$48,561.00	03/01/95	$ 5,817,265	$ 5,379,844	02/21/08		$ 478,462	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$48,561.00		$ 5,817,265	$ 5,379,844			$ 478,462	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(13,956)	10
11	Insurance Financing		X								3,910	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,046)	14
15	TOTALS (line 9+line14)						$ 5,817,265	$ 5,379,844			$ 468,416	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income-Related		X				$	$			$ (65)	1
2	Alloc. Sir Management	X									3,721	2
3	Alloc. Preferred Bookkeeping	X									1,204	3
4	Interest Income	X									(18,816)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (13,956)	21

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		$ 72,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 77,821	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,821	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 73,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 382	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 80,003	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	76,201	8
	1998	77,554	9
	1999	77,033	10
	2000	70,014	11
	2001	71,835	12

Accural for 2002 $71835.28 *1.03=73990.34

Allocation of R/E tax SIR $ 3853

Allocation of R/E tax Pref. Book $2133

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILSON CARE INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE 847-236-1111 FAX #: 847-236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-220-009-0000	Long Term Care Property	$ 71,835.28	$ 71,835.28
2.	See Attached	See Attached	$ 48,920.62	$ 5,212.66
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 120,755.90	$ 77,047.94

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WILSON CARE INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,020 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1985	$ 13,300	1
2					2
3	TOTALS			$ 13,300	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	65,366		20	3,441	3,441	59,051	9
10	Various			1986	161,365		20	8,493	8,493	140,624	10
11	Various			1987	49,380		20	2,598	2,598	40,783	11
12	Various			1989	49,210		20	2,461	2,461	33,367	12
13	Various			1990	105,470		20	5,274	5,274	63,736	13
14	Various			1991	29,903		20	1,494	1,494	17,281	14
15	Various			1992	69,669		20	3,484	3,484	36,777	15
16	Various			1993	61,688		20	3,087	3,087	29,281	16
17	Various			1994	55,691		20	2,917	2,917	24,598	17
18	Various			1995	87,144		20	4,360	4,360	32,699	18
19	Various			1996	303,393		20	15,172	15,172	97,667	19
20	Various			1997	145,411		20	7,348	7,348	35,060	20
21	Various			1998	34,959		20	1,748	1,748	7,950	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,627,856	84,749		47,467	(37,282)	738,302	68
69	Financial Statement Depreciation			35,486			(35,486)		69
70	TOTAL (lines 4 thru 69)		$ 2,846,505	$ 120,235		$ 109,344	$ (10,891)	$ 1,357,176	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,846,505	$ 120,235		$ 109,344	$ (10,891)	$ 1,357,176	1
2	TUCKPOINTING	1999	5,300		20	265	265	1,038	2
3	HVAC WORK	1999	27,900		20	1,395	1,395	5,231	3
4	S.I.R. REMODELING	1999	11,079		20	554	554	1,801	4
5	ROOFING	1999	975		20	49	49	196	5
6	BLINDS	1999	1,849		20	92	92	353	6
7	ELECTRICAL	1999			20				7
8	CUBICLE CURTAINS	1999	2,453		20	123	123	451	8
9	DOORS	1999			20				9
10	HEAT COOL SLEVE	1999	1,650		20	83	83	256	10
11	PIPE REPLACEMENT	1999	3,618		20	181	181	603	11
12	2 NEW CAR GATES	1999	5,780		20	289	289	963	12
13	FLOORING	1999	1,234		20	62	62	196	13
14	ELECTRICAL	1999	2,719		20	136	136	272	14
15	PAINTING	2000	15,000		20	750	750	1,938	15
16	FLOOR & WALL TILE	2000	13,197		20	660	660	1,595	16
17	KITCHEN TILES	2000	13,147		20	657	657	1,533	17
18	PUMP	2000	5,677		20	284	284	639	18
19	TILE WORK	2000	62,060		20	3,103	3,103	6,982	19
20	DINING ROOM	2000	24,287		20	1,214	1,214	2,732	20
21	TILE WORK	2000	2,013		20	101	101	219	21
22	PAINTING	2000	15,000		20	750	750	1,875	22
23	PAINTING	2000	30,000		20	1,500	1,500	3,625	23
24	PAINTING	2000	30,000		20	1,500	1,500	3,375	24
25	FIRE DOORS	2000	35,264		20	1,763	1,763	4,701	25
26	ROOM DIVIDER	2000	20,600		20	1,030	1,030	2,232	26
27	WINDOW TREATMENT	2000	1,046		20	52	52	147	27
28	WINDOW TREATMENT	2000	1,044		20	52	52	130	28
29	KITCHEN REMODEL	2000			20				29
30	ELECTRIC WORK	2000	2,585		20	129	129	323	30
31	STOWELL REMODEL	2000	1,798		20	90	90	218	31
32	PAINTING	2000	5,900		20	295	295	615	32
33	PAINTING	2000	24,447		20	1,222	1,222	2,546	33
34	TOTAL (lines 1 thru 33)		$ 3,214,127	$ 120,235		$ 127,725	$ 7,490	$ 1,403,961	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,214,127	$ 120,235		$ 127,725	$ 7,490	$ 1,403,961	1
2	TILE WORK	2000	8,474		20	424	424	883	2
3	KITCHEN REMODEL	2000	6,623		20	331	331	662	3
4	RADIATOR	2000	1,055		20	53	53	106	4
5	MIXING VALVE	2000	1,138		20	57	57	114	5
6	CONCRETE	2000	1,500		20	75	75	150	6
7	BORDERS	2000	542		20	27	27	54	7
8	CARPET	2000	633		20	32	32	64	8
9	INTERIOR SUPPLY	2000	1,582		20	79	79	158	9
10	DINING A/C	2000	1,239		20	62	62	124	10
11	CONCRETE	2000	1,000		20	50	50	100	11
12	WATER HEATER	2000	5,120		20	256	256	512	12
13	LIGHTS FIXTURE	2000	7,807		20	390	390	780	13
14	TUCKPOINTING	2000	2,440		20	122	122	244	14
15	FLOORING	2001	24,235		20	1,212	1,212	2,424	15
16	WINDOW TREATMENT	2001	6,946		20	347	347	694	16
17	DOORS	2001	6,905		20	345	345	690	17
18	ELEVATOR WORK	2001	5,690		20	285	285	451	18
19	SECURITY SYSTEM	2001	8,340		20	417	417	626	19
20	HVAC SYSTEM	2001	5,175		20	259	259	367	20
21	HVAC WORK	2001	11,902		20	595	595	645	21
22	PAINT	2001	718		20	36	36	72	22
23	BOOSTER HEATER	2001	1,523		20	76	76	89	23
24	FIRE DOOR	2001	1,221		20	61	61	107	24
25	DOORS	2001	1,851		20	93	93	155	25
26	BLINDS	2001	1,187		20	59	59	98	26
27	AQUASTAT	2001	1,064		20	53	53	93	27
28	FIRE DOOR	2001	1,227		20	61	61	92	28
29	BLINDS	2001	1,194		20	60	60	90	29
30	FIRE DOOR	2001	1,495		20	75	75	113	30
31	BLINDS	2001	1,194		20	60	60	80	31
32	CAMERA	2001	951		20	48	48	60	32
33	WINDOW TREATMENT	2001	6,946		20	347	347	694	33
34	TOTAL (lines 1 thru 33)		$ 3,343,044	$ 120,235		$ 134,172	$ 13,937	$ 1,415,552	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,343,044	$ 120,235		$ 134,172	$ 13,937	$ 1,415,552	1
2	BATHTUB LINER	2001	3,186		20	159	159	186	2
3	REFINISH TUB	2001	2,610		20	131	131	164	3
4	HOT WATER HEATER	2001	1,789		20	89	89	178	4
5	WATER HEATER	2001	1,276		20	64	64	112	5
6	LIGHTING	2001	2,060		20	103	103	146	6
7	PLUMBING REPAIR	2001	1,948		20	97	97	113	7
8	CABINETS	2002	3,851		20	642	642	642	8
9	PLUMBING	2002	24,086		20	803	803	803	9
10	MODULE & CABLE	2002	9,897		20	495	495	495	10
11	TILE	2002	1,076		20	36	36	36	11
12	FREEZER MOTOR	2002	1,151		20	58	58	58	12
13	WALK-IN FREEZER	2002	1,007		20	50	50	50	13
14	GREASE TRAPS	2002	1,150		20	38	38	38	14
15	WATER LINE REPAIR	2002	2,950		20	98	98	98	15
16	HOT WATER HEATER	2002	1,120		20	37	37	37	16
17	WALL REPAIR	2002	440		20	15	15	15	17
18	BLINDS	2002	1,194		20	40	40	40	18
19	DRY WALL	2002	4,000		20	133	133	133	19
20	INSTALL TILE	2002	992		20	33	33	33	20
21	BATHTUB LINER	2002	716		20	24	24	24	21
22	DOORS	2002	1,608		20	50	50	50	22
23	WINDOW TREATMENT	2002	2,493		20	83	83	83	23
24	PAINT	2002	814		20	20	20	20	24
25	PAINT	2002	949		20	32	32	32	25
26	HEATER	2002	1,698		20	57	57	57	26
27	DRY WALL	2002	3,000		20	100	100	100	27
28	BATHTUB LINER	2002	631		20	21	21	21	28
29	CURTAIN	2002	489		20	16	16	16	29
30	BOILER	2002	2,004		20	67	67	67	30
31	PAINT	2002	512		20	17	17	17	31
32	BATHTUB LINER	2002	1,848		20	62	62	62	32
33	WALL COVER	2002	5,031		20	168	168	168	33
34	TOTAL (lines 1 thru 33)		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,621	$ 120,235		$ 138,010	$ 17,775	$ 1,419,646	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1985		$ 1,539,800	$ 81,609	35	$ 43,994	$ (37,615)	$ 712,190	4
5	Alloc. SIR		1993		15,508	492	35	443	(49)	4,209	5
6	Alloc SIR		1993		28,010	889	35	800	(89)	7,602	6
7											7
8											8
	Improvement Type**										
9	Allocation from Preferred Bookkeeping			1997	19,368	434	20	968	534	5,625	9
10	Allocation from Preferred Bookkeeping			1999	154	-	20	8	8	27	10
11	Allocation from Preferred Bookkeeping			2000	971	-	20	49	49	117	11
12	Allocation from SIR Management			1993	12,030	335	20	607	(272)	5,955	12
13	Allocation from SIR Management			1994	38	-	20	4	4	31	13
14	Allocation from SIR Management			1995	275	-	20	14	14	102	14
15	Allocation from SIR Management			1999	1,307	44	20	65	21	210	15
16	Allocation from SIR Management			2000	789	83	20	39	(44)	106	16
17											17
18	Allocation from SIR Prop-SIR Management			2002	111	-	20	3	3	3	18
19	Allocation from SIR Prop-SIR Management			1999	3,549	355	20	177	(178)	621	19
20	Allocation from SIR Prop-SIR Management			1998	1,696	170	20	85	(85)	382	20
21	Allocation from SIR Prop-SIR Management			1997	106	11	20	5	(6)	34	21
22	Allocation from SIR Prop-SIR Management			1994	267	7	20	13	6	113	22
23	Allocation from SIR Prop-SIR Management			1993	454	12	20	23	11	216	23
24											24
25	Allocation from SIR Prop-Pref Bookkeeping			2002	61	-	20	2	2	2	25
26	Allocation from SIR Prop-Pref Bookkeeping			1999	1,965	197	20	98	(99)	344	26
27	Allocation from SIR Prop-Pref Bookkeeping			1998	939	94	20	47	(47)	211	27
28	Allocation from SIR Prop-Pref Bookkeeping			1997	58	6	20	3	(3)	19	28
29	Allocation from SIR Prop-Pref Bookkeeping			1994	148	4	20	7	3	63	29
30	Allocation from SIR Prop-Pref Bookkeeping			1993	252	7	20	13	6	120	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,627,856	$ 84,749		$ 47,467	$ (37,826)	$ 738,302	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 516,066	$ 59,376	$ 37,257	$ (22,119)	10	$ 369,530	71
72	Current Year Purchases	7,928	2,010	829	(1,181)	10	829	72
73	Fully Depreciated Assets	330,738				10	330,738	73
74								74
75	TOTALS	$ 854,732	$ 61,386	$ 38,086	$ (23,300)		$ 701,097	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,298,653	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 181,621	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 176,096	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,525)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,120,743	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 15,605 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1999 Dodge	$ 450.00	$ 5,400	17
18					18
19					19
20					20
21	TOTAL		$ 450.00	$ 5,400	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,504	$ 5,596	1
2	Cash-Patient Deposits	20,799	20,799	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,170,412	1,170,412	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,562	13,562	6
7	Other Prepaid Expenses	585	585	7
8	Accounts Receivable (owners or related parties)	535,000	535,000	8
9	Other(specify): See Supplemental Schedule	23,155	23,155	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,767,017	$ 1,769,109	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,200	13
14	Buildings, at Historical Cost		1,539,800	14
15	Leasehold Improvements, at Historical Cost	1,169,826	1,169,826	15
16	Equipment, at Historical Cost	1,063,958	1,093,958	16
17	Accumulated Depreciation (book methods)	(1,385,699)	(2,826,149)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	4,125	60,450	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 852,210	$ 1,063,085	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,619,227	$ 2,832,194	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 132,838	$ 132,838	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,803	21,803	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,784	157,784	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,977	9,977	31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,800	73,800	32
33	Accrued Interest Payable		27,271	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	24,450	24,450	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	4,772	4,772	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 425,424	$ 452,695	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,379,844	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,379,844	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 425,424	$ 5,832,539	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,193,803	$ (3,000,345)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,619,227	$ 2,832,194	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,835,111	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,835,111	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,222,692	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(864,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 358,692	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,193,803	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,735,159	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,735,159	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,816	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,816	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	1,742	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,742	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,755,717	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	968,237	31
32	Health Care	1,487,624	32
33	General Administration	1,169,087	33
	B. Capital Expense		
34	Ownership	799,672	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	108,405	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,533,025	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,222,692	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,222,692	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,773	2,086	$ 64,548	$ 30.94	1
2	Assistant Director of Nursing	1,858	2,094	50,990	24.35	2
3	Registered Nurses	14	14	331	23.64	3
4	Licensed Practical Nurses	13,582	14,503	271,505	18.72	4
5	Nurse Aides & Orderlies	70,126	74,717	531,135	7.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,763	1,849	26,120	14.13	9
10	Activity Assistants	7,032	7,365	56,366	7.65	10
11	Social Service Workers	19,225	20,880	277,980	13.31	11
12	Dietician					12
13	Food Service Supervisor	1,922	2,086	33,913	16.26	13
14	Head Cook	3,878	4,313	34,321	7.96	14
15	Cook Helpers/Assistants	13,727	14,457	97,703	6.76	15
16	Dishwashers					16
17	Maintenance Workers	3,421	3,493	37,174	10.64	17
18	Housekeepers	16,180	16,869	116,146	6.89	18
19	Laundry					19
20	Administrator	1,963	2,080	82,556	39.69	20
21	Assistant Administrator	1,016	1,647	17,520	10.64	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,907	7,556	81,697	10.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,694	5,094	61,897	12.15	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,418	5,418	13,953	2.58	33
34	TOTAL (lines 1 - 33)	174,498	186,520	$ 1,855,855 *	$ 9.95	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,000	01-03	35
36	Medical Director	Monthly	2,400	09-03	36
37	Medical Records Consultant	96	4,128	10-03	37
38	Nurse Consultant	1,079	39,204	10-03	38
39	Pharmacist Consultant	30	1,440	10-03	39
40	Physical Therapy Consultant	55	17,580	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	3,000	12-03	45
46	Other(specify)				46
47	Psychosocial Program	Monthly	6,193	12-03	47
48	Director of Food Services	SIR MGMT	20,196	01-03	48
49	TOTAL (lines 35 - 48)	1,260	$ 106,141		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	966	$ 41,017	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	966	$ 41,017		53

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charlene Hill-Jeon	Administrator	0	$ 82,556
Ralei Evans	Assistant Admin	0	17,520
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,076

B. Administrative - Other

Description	Amount
Mangement Fee- See Attached	$ 250,198
Admin-Other see attached	44,544
SIR Management-Council Dues	12,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 307,342
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Proclaim	Third Party start up fees	$ 252
Personnel Planner	Unemployment Consulant	1,167
Perferred BookKeeping	Bookkeeping	61,776
Perferred BookKeeping	Computer Service	4,752
FR & R	Accounting	18,945
Perferred BookKeeping	Accounting	41,250
ICS	Website	1,000
LTC Solution	Computer Service	1,320
Micheal Best & Friedrich	Legal	18,890
SIR Management	Legal	7,128
SIR Management	Dir of Reg Services	16,044
Meyer Magence	Legal	250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 172,774

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,943
Unemployment Compensation Insurance	10,856
FICA Taxes	140,226
Employee Health Insurance	38,512
Employee Meals	17,739
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,124
Employee Benefit	10,041
Union Health and Welfare	61,539
401K Plan	2,233
TOTAL (agree to Schedule V, line 22, col.8)	$ 305,214

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,803
Health Care Worker Background Check	244
(Indicate # of checks performed)	
IL Council Due	8,363
License	2,892
Alloc. Extended Care Dues	20
Alloc. Preferred Bookkeeping Dues	222
Alloc. SIR Management Dues	19
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,563

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,138
Alloc. SIR Management	219
Alloc. Preferred Bookkeeping	44
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,401

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WILSON CARE INC. # 0029975 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL $ 11464**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,520** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **108,405**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **17,739** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln.14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.